King County
Work & Life Benefits
Medical Plan Summary

Alliant Plan

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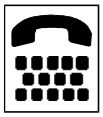
Final (revised)
December 17, 1999

Directory

If you have questions about ...	Contact …
• Benefits eligibility • Enrollment • When coverage begins • Other King County Work & Life Benefits	**Benefits & Well-Being** at 206-684-1556 (8:30 a.m. – 4:30 p.m. Monday – Friday, except 10:30 a.m. – 4:30 p.m. Thursday) www.metrokc.gov/ohrm/benefits Exchange Building Mail Stop EXC-HR-1030 821 Second Avenue Seattle WA 98104-1598
• Providers (primary care physicians, hospitals, etc.) • Changing your primary care physician • Filing claims • Other plan details (covered expenses, limitations, exclusions, specific medical conditions or treatment, etc.)	**Virginia Mason/Group Health Alliant** at 1-800-442-4038 (7:30 a.m. – 5 p.m. Monday – Friday) www.ghc.org/alliance/allisel.html PO Box 1207 Seattle WA 98111-1207
• Advice on urgent care situations (after office hours)	**Group Health's Consulting Nurse Service** at 1-800-910-8884
• Preauthorization for mental health and chemical dependency treatment	**Behavioral Health Access Unit** at 1-888-287-2680 (if you have a Group Health PCP), or **Virginia Mason Managed Mental Health and Chemical Dependency Services** at 1-800-437-3971 (if you have a Virginia Mason PCP), or **King County's Making Life Easier Program** at 1-888-874-7290 (24 hours, 7 days a week)

The information in this booklet is available in accessible formats by calling Benefits and Well-Being at 206-684-1556 (voice) or through Washington State Telecommunication Relay Service at 1-800-833-6388.



Although this booklet includes certain key features and brief summaries of this medical coverage, it does not provide detailed descriptions. If you have specific questions, contact Alliant or Benefits and Well-Being.

We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and the insurance contracts or other legal documents, the legal documents will always govern.

King County intends to continue this plan indefinitely but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents.

This booklet does not create a contract of employment with King County.

Learn More About … *On Page …*

Learn More About (cont'd)… On Page …

Highlights

Here are a few highlights of your coverage under the Alliant Plan:

- You do not pay an annual deductible under this plan
- You pay a copay for each office visit
- You receive network benefits only (generally paid at 100%), which means you must see a network provider (see page 26 for a definition of network provider) for care unless you have an emergency or your primary care physician refers you outside the network.

Important Facts

This booklet describes the Alliant medical plan. However, there are many important topics including laws, regulations and county provisions that affect more than just this plan. These provisions can change frequently. To be more efficient, and avoid repetition, we included the following topics in your "Important Facts" booklet:

- What Happens If (you take a leave of absence, become disabled, etc.)
- Eligibility
- Enrolling in the Plans
- When Coverage Begins
- Qualified Medical Child Support Order (QMCSO)
- When Coverage Ends
- Continuation of Coverage (COBRA)
- Assignment of Benefits
- Third Party Claims
- Recovery of Overpayments
- Termination and Amendment of the Plans
- Medical Plan Participant Bill of Rights.

Who's Eligible

Refer to your "Important Facts" booklet for information about eligibility and appeal of eligibility.

Cost

When you receive medical care, you pay:

- Required copays, paid at the time of the service
- Coinsurance amounts not covered by the plan
- Expenses for services or supplies not covered by the plan.

A billing fee may be charged by Alliant if copays or bills reflecting expenses not covered by the plan are not paid on time. Payment of the amount billed must be received within 30 days of the billing date.

See your enrollment materials for information related to any monthly cost of coverage. See the "Medical Plan Summary" on page 2 for more information on copays and coinsurance amounts.

Enrolling in the Plan

If you are a newly hired employee, you must submit a completed enrollment form to Benefits and Well-Being within 30 days of your hire date; otherwise, you will receive default coverage. See your enrollment materials for details.

Making Changes

Each year during open enrollment, you may change your elections. Under certain circumstances, you may make changes during the year. Refer to your "Important Facts" booklet for details.

When Coverage Begins

Refer to your "Important Facts" booklet for information on when coverage begins.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants (see page 16) and growth hormones (see page 10). If you end employment with King County, please refer to page 22 for information on how your participation with this plan could be credited against another plan with a preexisting condition limit.

How the Alliant Plan Works

Medical Plan Summary

The following table summarizes covered services and supplies under the Alliant Plan and identifies related coinsurance, copays, maximums and limitations. Please refer to "Covered Expenses" and "Expenses Not Covered" for more information on your medical benefits. Only medically necessary services and supplies are covered. PCP refers to primary care physician.

	Alliant Plan	For more information refer to …
Annual deductible	None	–
Annual out-of-pocket maximum	$1,000/person; $2,000/family	–
Lifetime maximum	None	–
Covered Expenses	**Plan Pays**	
Alternative care	100% for specific services after $10 copay/visit (PCP referral required)	Page 7
Ambulance services	80%	Page 7

Covered Expenses	Alliant Plan	For more information refer to …
Chemical dependency treatment	Up to $10,000 in plan payments any 24 consecutive months	Page 8
- Inpatient	100%	
- Outpatient	100% after $10 copay/visit	
Chiropractic care (manipulative therapy)	100% after $10 copay/visit, (you must use a designated Alliant Plan provider)	Page 8
Diabetes care training and supplies	100% for training 80% for equipment and pumps	Page 8
Durable medical equipment, prosthetics, orthopedic appliances		Page 8
- Nasal CPAP devices	80%	
- Orthopedic appliances	80%	
- Post-mastectomy bras	80%	
- Prosthetic devices	80%	
Emergency care (in an emergency room)		Page 9
- Emergency care	100% after $50 copay/visit (waived if admitted to a network facility)	
- Nonemergency care	Not covered	
Family Planning	100% after $10 copay/visit	Page 10
Growth hormones	See prescription drugs	Page 10
Hearing aids	100% up to $300/ear/3-year period	Page 10
Home health care	100%	Page 10
Hospice care	100% up to 6 months	Page 10
Hospital care	100%	Page 11
Infertility	Not covered	–
Injury to teeth	Not covered	–
Inpatient care alternatives	100%	Page 11
Lab, x-rays and other diagnostic testing	100%	Page 12
Maternity care		Page 12
- Delivery and related hospital care	100%	
- Prenatal and postpartum care	$10 copay/visit	
Mental health care		Page 12
- Inpatient	80% up to 12 days/year	
- Outpatient	100% after $20 copay/individual, family or couple for each visit and a $10 copay/group session; up to 20 visits a year	

Covered Expenses	Alliant Plan	For more information refer to …
Neurodevelopmental therapy - Inpatient - Outpatient	 100% up to 60 days/condition/year 100% after $10 copay/visit; up to 60 visits/condition/year	Page 13
Physician and other medical and surgical services	100% after $10 copay/visit	Page 13
PKU formula	100%	Page 14
Prescription drugs - Network pharmacy - Mail order	 100% after $5 copay/generic or $10 copay/brand name; 30-day supply 100% after $5 copay/generic or $10 copay/brand name; 30-day supply	Page 14
Preventive care (including well-child checkups; routine health and hearing exams)	100%	Page 14
Radiation therapy, chemotherapy and respiratory therapy	100% after $10 copay/visit	Page 14
Reconstructive services	100%	Page 15
Rehabilitative services - Inpatient - Outpatient	Up to 60 visits/condition/year 100% 100% after $10 copay/visit	Page 15
Skilled nursing facility	100%❶	Page 15
TMJ - Inpatient - Outpatient	Up to $1,000 maximum/person/year in plan payments; lifetime benefit maximum of $5,000/person 100% 100% after $10 copay/visit	Page 15
Tobacco cessation - Sessions - Nicotine replacement	 100% 100% or $5 copay/30 day-supply, whichever is less	Page 16
Transplants	100%	Page 16
Urgent care	100% after $10 copay/visit	Page 16
Vision exams	100% after $10 copay/visit up to 1 exam/person in 12 consecutive months **(Alliant covers exams only – see your Vision Plan Summary booklet for information about your comprehensive vision benefits through Vision Service Plan)**	Page 17

❶ Must be approved by Alliant as an appropriate alternative to hospitalization.

How the Plan Pays Benefits

The following chart shows how benefits are determined for most covered expenses.

Plan Feature	Alliant Plan
You pay copays for some services	See "Medical Plan Summary" for services that require copays and amounts
After the copays, the plan pays for most covered services at this level …	100%

Annual Out-of-Pocket Maximum

The out-of-pocket maximum is generally the most you pay toward copays each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the year.

The following do not apply to the out-of-pocket maximum:

- Inpatient mental health
- Outpatient mental health in excess of 20 visit limit
- Medical supplies and devices
- Hearing aids
- Prescription drugs
- Durable medical equipment
- Self-referred chiropractic care
- Occupational, physical and speech therapy
- Blood and blood products
- Health education
- Residential day treatment
- Eyeglasses and contact lenses
- Services and supplies not covered by the plan.

The Network

All providers – clinics, doctors and other health care professionals who make up the network – are carefully screened by Alliant. Doctors or other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories.

Selecting a Primary Care Physician (PCP)

Your primary care physician is your personal doctor and the starting point for all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your primary care physician will arrange it.

You are strongly encouraged to select a primary care physician from Virginia Mason, Group Health or any of the contracted primary care providers listed in the network provider directory when you enroll. Each family member may have a different primary care physician. A Welcome Caller will contact you shortly after you enroll to help you make this selection. The provider directory is updated periodically; for current information about providers, contact the Alliant Plan at 1-800-442-4038.

Selecting a Primary Care Physician (PCP) (cont'd)

Continuity of your care is important – and easier to achieve if you establish a long-term relationship with your primary care physician. However, if you find it necessary to change your primary care physician, call Alliant.

Specialists

Your primary care physician provides or coordinates your medical care. Before you see a specialist, you must have a referral from your primary care physician. In most cases, your doctor will refer you to a network specialist. If you prefer to see a particular specialist, you should discuss this with your primary care physician. He or she will accommodate your request if practical and medically appropriate.

When you are referred, be sure to get a copy of the referral form from your primary care physician and take it to your specialist. To allow your primary care physician to coordinate your care most effectively, check back with him or her after a specific time or number of visits to a specialist.

Sometimes a specialist wants you to see another specialist. In those instances, your specialist will discuss your care with your primary care physician who will determine if the second referral is medically necessary.

If you see a specialist without a referral, benefits may not be payable.

Accessing Care

To receive benefits:

- You make an appointment with the network provider
- You pay the $10 office visit copay at the time you receive health care services
- The plan pays 100% for most covered services
- The plan handles all forms and paperwork.

To receive most plan benefits, your primary care physician must provide or coordinate your care. However, here are a few exceptions to this rule. You may receive these services from *any network provider* — without a referral from your primary care physician:

- Chiropractic care or manipulative therapy services
- Outpatient mental health and chemical dependency services
- Routine vision exams
- Tobacco cessation programs and health promotion classes
- Urgent care
- Women's health care services (for example, maternity care, reproductive health services and gynecological care).

You may receive benefits when you see non-network providers in the following situations only:

- Emergency care
- Your network provider refers you to a non-network provider.

Second Opinions

On occasion, you may want a second opinion. To receive benefits for the second opinion, you must have a referral from your primary care physician.

Obtaining Preauthorization

You must obtain preauthorization if you don't see your primary care physician for these services:
- Alternative care
- Outpatient chemical dependency treatment
- Outpatient mental health care
- Women's health care services (if the services involve hospitalization or surgery).

When to Call: You do not need preauthorization for emergencies (including detoxification). However, you (or a family member or hospital staff member) are expected to call within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

How to Call: To obtain preauthorization for your care, you or your physician must call Alliant at 206-901-6210 or 1-800-442-4038.

To obtain preauthorization for mental health care and chemical dependency treatment: You also may call King County's Making Life Easier Program at 1-888-874-7290. Staff will obtain preauthorization for your care and refer you to a provider for treatment.

If You Don't Call: If your care is not preauthorized as described above, your care will not be covered.

If You Live Outside the Service Area

This plan does not provide out-of-area benefits. If you live in the service area but your covered family members live away from home, see page 19 for more information.

Covered Expenses

The following section describes expenses covered by this plan. For information on the level of benefits you receive (for example, related coinsurance, copays, maximums and limitations), refer to the "Medical Plan Summary" starting on page 2. Also see "Expenses Not Covered" on page 17.

To be covered, services and supplies must be medically necessary.

Alternative Care

You must have a referral from your primary care physician to receive benefits for acupuncture, naturopathy or massage therapy. Contact Alliant for more information on referral guidelines.

Covered services include:
- Acupuncture services, limited to services for chronic pain symptoms that meet referral guidelines
- Home births; you may see any midwife participating in the Alliant network of licensed midwives for covered prenatal and home birth services
- Massage therapy services, unless for recreational, sedative or palliative reasons; soft-tissue massage must be medically indicated
- Naturopathy services, limited to chronic conditions that meet referral guidelines.

Ambulance Services

Services of an ambulance company are covered if:
- Ordered or approved by your primary care physician
- Other transportation would endanger your health, and
- The transportation is not for personal or convenience reasons.

Chemical Dependency Treatment

Inpatient and outpatient chemical dependency services are covered. Your primary care physician can arrange these services, or – in the case of outpatient care – you may call either of these programs directly:

- Behavioral Health Access Unit at 1-888-287-2680
- Virginia Mason Managed Mental Health and Chemical Dependency Program at 1-800-437-3971.

You may also receive these benefits through King County's Making Life Easier Program by calling 1-888-874-7290. Staff will obtain preauthorization for your care and refer you to a provider for treatment.

Treatment may include the following inpatient or outpatient services:

- Covered prescription drugs and medicines
- Diagnostic evaluation and education
- Organized individual and group counseling

Detoxification services are covered as any other medical condition and are not subject to the chemical dependency limit. Chemical dependency means a physiological and/or psychological dependency on a controlled substance and/or alcoholic beverages, where your health is substantially impaired or endangered, or your ability to function socially or work is substantially disrupted.

Chiropractic Care

Medically necessary manipulative therapy of the spine and extremities is covered. You do not need a referral from your primary care physician before you see a network chiropractor or osteopath. X-rays associated with manipulative therapy are covered when provided at an Alliant radiology facility.

Diabetes Care Training and Supplies

Diabetes care training includes diet counseling, enrollment in diabetes registry and a wide variety of education materials.

Covered supplies include:

- Blood glucose monitoring reagents
- Diabetic monitoring equipment
- External insulin pumps
- Insulin syringes
- Lancets
- Urine testing reagents.

Durable Medical Equipment, Prosthetics, Orthopedic Appliances

Covered equipment and appliances include:

- Nasal CPAP devices
- Orthopedic appliances
- Post-mastectomy bras
- Prosthetic devices.

Durable medical equipment is covered if:
- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your primary care physician, and
- Primarily and customarily used only for medical purposes.

Covered items include:
- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses or braces
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- External breast prosthesis (covered at 100%) and bra following mastectomy (covered at 50%); 1 external breast prosthesis is available every 2 years (per diseased breast), and 2 post-mastectomy bras are available every 6 months (up to 4 in any consecutive 12 months)
- Non-prosthetic orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- Ostomy supplies
- Oxygen and oxygen equipment for its administration
- Purchase of nasal CPAP devices and initial purchase of associated supplies (you must rent the device for 1 month before purchase to establish compliance)
- Rental or purchase (decided by the plan) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price).

Emergency Care

Emergency care is covered. Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient if not treated immediately. You do not need a referral from your primary care physician before you receive emergency room care. See page 18 for instructions on what to do if you need emergency or urgent care.

Examples of conditions that might require emergency care include, but are not limited to:
- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion – especially after a head injury.

If you are admitted to a health care facility, you must notify Alliant within 24 hours. You may be required to transfer your care to a network provider and/or Alliant facility. If you refuse to transfer to an Alliant facility, all further costs incurred during the hospitalization are your responsibility.

In general, follow-up care that is a direct result of the emergency must be received through Alliant. Nonemergency use of an emergency facility is not covered.

Family Planning

Covered family planning expenses include:
- Family planning counseling services
- Services to insert intrauterine birth control devices (IUDs)
- Sterilization procedures
- Voluntary termination of pregnancy.

The plan does not cover:
- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit described on page 14.

Growth Hormones

Growth hormones are covered, subject to the pharmacy copay. You or your family member will not be eligible for any growth hormone benefits until the first day of the 13th month of continuous coverage under this plan (unless continually covered under this plan until birth).

Hearing Aids

Hearing aids including fitting, rental and repair are covered.

Home Health Care

Home health care is covered if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable recurring need. Unwillingness to travel and/or arrange for transportation does not constitute an inability to leave home. If you have an approved plan of treatment, covered services include:
- Medical social worker and limited home health aide
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative speech therapy.

The following services are not covered:
- Any care provided by or for a member of the patient's family
- Any other services rendered in the home that are not specifically listed as covered
- Custodial care and maintenance care
- Housekeeping or meal services
- Private duty or continuous care in the patient's home.

Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician; nurse; medical social worker; physical, speech, occupational or respiratory therapist; or a home health aide under the supervision of a registered nurse.

Hospice services are covered if:

- A network provider determines the patient's illness is terminal, with life expectancy of 6 months or less, and can be appropriately managed in the home
- The patient has chosen comforting and supportive services rather than treatment aimed at curing their terminal illness
- The patient has elected in writing to receive hospice care through the Alliant-approved hospice program, and
- The patient has a primary care person who will be responsible for the patient's home care.

One period of continuous home care service is covered. A continuous home care period is skilled nursing care provided in the home during a period of crisis to maintain a terminally ill patient at home. Continuous home care may be provided for 4 or more hours a day for up to 5 days, or a total of 72 hours, whichever occurs first. A network provider must determine the patient would otherwise require hospitalization.

Continuous respite care may be covered for up to 5 days in each 3 months of hospice care. Respite care must be given in the most appropriate setting as determined by your network provider. See page 27 for a definition of respite care.

The following services are not covered:

- Any services provided by members of the patient's family
- Bereavement or pastoral counseling
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
  - House cleaning or upkeep
  - Sitter or companion services for either the plan participant who is ill or for other family members
  - Transportation.

Hospital Care

The following hospital care expenses are covered under this plan:

- Drugs listed in the plan formulary (see "Definitions" on page 25 for more information on the plan formulary)
- Hospital services
- Room and board
- Special duty nursing.

Infertility

Infertility benefits are not covered under this plan.

Injury to Teeth

Injuries to teeth are not covered.

Inpatient Care Alternatives

Your primary care physician may develop a written treatment plan for care in an equal or more cost-effective setting than a hospital. All hospital benefit terms, maximums and limitations apply to the inpatient care alternatives.

Lab, X-ray and Other Diagnostic Testing

This plan covers diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. See "Preventive Care" on page 14 for more information on routine diagnostic testing (for example, mammograms).

Maternity Care

Maternity care is covered if provided by a:
- Physician
- Provider licensed as a midwife by Washington state.

Covered maternity care includes:
- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies
- Postpartum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders of the unborn child
- Screening and diagnostic procedures during pregnancy.

The plan does not cover home pregnancy tests.

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Care

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:
- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

Mental health services are available through both Virginia Mason and Group Health facilities. The Virginia Mason Managed Mental Health and Chemical Dependency Program will coordinate your care.

Your primary care physician can arrange for mental health services, or you may call Virginia Mason Managed Mental Health and Chemical Dependency Program at 1-800-437-3971.

You also may receive these benefits through King County's Making Life Easier Program by calling 1-888-874-7290. Staff will obtain preauthorization for your care and refer you to a provider for treatment.

The following mental health services are not covered:
- Biofeedback
- Custodial care
- Day treatment
- Specialty programs for mental health therapy not provided by Alliant
- Treatment of sexual disorders.

Neurodevelopmental Therapy

The plan covers neurodevelopmental therapy for covered family members age 6 and younger, including:
- Hospital care
- Maintenance of the patient when his or her condition would significantly worsen without such services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physicians' services
- Services to restore and improve function.

The plan does not cover:
- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

Newborn Care

The plan covers newborns under the mother's coverage for the first 3 weeks, as required by Washington state law. To continue the newborn's coverage after 3 weeks, the newborn must be eligible and enrolled by the deadline. See "Important Facts" for details.

Physician and Other Medical and Surgical Services

Several other medical and surgical services are covered by this plan, including:
- Blood and blood derivatives and their administration
- Diabetic supplies including insulin syringes, lancets, urine-testing reagents and blood-glucose monitoring reagents
- Nonexperimental implants limited to cardiac devices, artificial joints and intraocular lenses
- Outpatient diagnostic radiology and laboratory services
- Outpatient radiation therapy and chemotherapy
- Outpatient surgical services
- Outpatient total parenteral nutritional therapy
- Services of a podiatrist
- Services performed by a network provider or oral surgeon including: reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth; incision of salivary glands and ducts
- Treatment of growth disorders by growth hormones.

PKU Formula

The plan covers medical dietary formula that treats Phenylketonuria (PKU).

Prescription Drugs

Benefits are provided for legend prescription drugs and other covered items (including insulin, injectables and contraceptive drugs and devices) when you use a network pharmacy, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:

- Filled at a network pharmacy
- Included on the plan's drug formulary, and
- Prescribed by a network provider for covered conditions.

The plan does not cover:

- Dental prescriptions
- Drugs for cosmetic uses
- Drugs for treatment of sexual dysfunction disorders
- Drugs not approved by the FDA and in general use as of March 1 of the previous year
- Drugs not on the plan's formulary
- Over-the-counter drugs.

To fill your prescription through a network pharmacy, show the pharmacist your Alliant Diversified Drug Card.

If you need a *refill*, check the label on the prescription container; some may be refilled without consulting your provider. The number of refills will be indicated on the label. If you need your provider's approval to refill your medication, call your pharmacy before you need to begin taking the last of your medication. The pharmacy will need time to order your medicine and contact your provider for approval.

You may receive up to a 30-day supply per copay. Generic drugs will be used whenever available. Brand-name drugs will be used if there is no generic equivalent. If available at the network pharmacy, you may buy specific brand-name drugs by paying the higher copay.

Preventive Care

You don't need a referral from your primary care physician before you see a network provider for routine vision exams and women's health care services (such as maternity care, reproductive health services and gynecological care).

The plan covers the following preventive care:

- Most immunizations and vaccinations for children
- Routine hearing exams (once in 12 consecutive months)
- Routine mammograms (age and risk factor will determine frequency)
- Routine physicals for adults and children (age and risk factor will determine frequency)
- Routine vision exams (once in 12 consecutive months).

Radiation Therapy, Chemotherapy and Respiratory Therapy

Covered expenses include radiation therapy, high-dose chemotherapy and stem cell support, and respiratory therapy services.

Reconstructive Services

Reconstructive services are covered to correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient's appearance (the reconstructive services must, in the opinion of a network provider, be reasonably expected to correct the condition).

Benefits available for covered individuals who are receiving benefits for a mastectomy and elect breast reconstruction in connection with the mastectomy in a manner determined in consultation with the patient and attending physician include:

- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits (see the Medical Plan Summary beginning on page 2 for details).

Rehabilitative Services

Covered inpatient and outpatient rehabilitative services are limited to physical, occupational and speech therapy to restore function after illness, injury or surgery.

The plan does not cover:

- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

Rehabilitative services are covered only when the plan determines they are expected to result in significant, measurable improvement within 60 days. Rehabilitative services for chronic conditions are not covered.

Skilled Nursing Facility

Skilled nursing facility services are covered when preauthorized by Alliance as an appropriate cost-saving alternative to acute care hospitalization.

TMJ

Medical and surgical services and related hospitalizations for the treatment of temporomandibular joint (TMJ) disorders are covered when medically necessary. Coverage is subject to the limitations outlined in the "Medical Plan Summary" starting on page 2. Orthognathic (jaw) surgery, radiology services and TMJ specialist services, including the fitting and adjustment of splints, also are covered. TMJ appliances are covered under the orthopedic appliances benefit described on page 8.

The following services, including related hospitalizations, are not covered by the plan regardless of origin or cause:

- All dental services (except as noted above), including orthodontic therapy
- Orthognathic (jaw) surgery in the absence of a TMJ diagnosis
- Treatment for cosmetic purposes.

Tobacco Cessation

You do not need a referral from your primary care physician before you see a network provider for these services.

Services related to tobacco cessation are covered, limited to:
- 1 course of nicotine replacement therapy a year if you're actively participating in the Alliant Free and Clear Program
- Educational materials
- Participation in 1 program a year.

Transplants

You or your family member will not be eligible for any *organ transplant* benefits until the first day of the 13th month of continuous coverage under this plan (unless continuously covered under this plan since birth).

The following transplants are covered:
- Bone marrow
- Cornea
- Heart
- Heart-lung
- Kidney
- Liver
- Lung (single or double)
- Pancreas/kidney (simultaneous).

Transplant services must be received at a facility designated by Alliant and are limited to:
- Evaluation testing to determine recipient candidacy
- Follow-up services for specialty visits, rehospitalization and maintenance medications
- Transplantation (limited to costs for surgery and hospitalization related to the transplant, and medications).

The following donor expenses for a covered organ recipient are covered:
- Excision fees
- Matching tests
- Procurement center fees
- Travel costs for a surgical team.

The plan does not cover:
- Donor costs reimbursable by the organ donor's insurance plan
- Living expenses
- Transportation expenses.

Urgent Care

This plan covers urgent care, which is treatment for conditions that are not life threatening but may need immediate attention, for example:
- Ear infections
- High fevers
- Minor burns.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown in the "Medical Plan Summary".

See page 18 for instructions on what to do if you need urgent care.

Vision Exams

This plan covers routine vision exams as described in the Medical Plan Summary starting on page 2. Your separate vision plan provides eye exams, prescription lenses and frames. See your Vision Plan Summary booklet for details.

Expenses Not Covered

In addition to the limitations and exclusions described in other sections of this booklet, the plan does not cover:

- Orthopedic shoes not attached to an orthopedic appliance and arch supports including custom shoe inserts or their fitting except for therapeutic shoes and shoe inserts for severe diabetic foot disease
- Artificial or mechanical hearts
- Benefits covered by other insurance
- Biofeedback
- Complications of noncovered surgical services
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Convalescent or custodial care
- Corrective appliances and artificial aids including eyeglasses, contact lenses or services related to their fitting
- Cosmetic services, including treatment for complications of cosmetic surgery that is elective or not covered
- Court-ordered services or programs not judged medically necessary by the network provider
- Dental care, surgery, services and appliances, except as described in "Physician and Other Medical and Surgical Services" on page 13
- Diabetic meals and some education materials
- Drugs, medicine and injections not listed as covered in the plan's formulary
- Evaluations and surgical procedures to correct refractions not related to eye pathology
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, recreational or school activities
- Experimental or investigative treatment as described on page 24
- Hypnotherapy or any related services
- Medicine or injections for anticipated illness while traveling
- Methadone maintenance programs
- Obesity treatment, services or items, except for nutritional counseling by network staff
- Orthoptic (eye training) therapy
- Over-the-counter drugs (medicine and devices not requiring a prescription)
- Personal comfort items, such as telephones or television
- Physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including obtaining or continuing employment or insurance or government licensure
- Routine foot care

Expenses Not Covered (cont'd)

- Services or supplies resulting from the loss or willful damage to covered appliances, devices, supplies or materials provided by Alliant
- Services provided by government agencies, except as required by federal or state law
- Sterility, infertility or sexual dysfunction testing or treatment including Viagra, penile implants, vascular or artificial reconstruction, sterilization reversal or sex transformations
- Weight reduction, cardiac or pulmonary rehabilitation, gambling or other specialty treatment programs
- Work-incurred injury, illness or condition treatment.

What Happens If

If You Need Emergency Care

Emergency care treats medical conditions that threaten loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your Alliant identification card.
- If you're admitted to a non-network facility, you must call 206-901-6210, or 1-800-442-4038 outside Seattle – within 24 hours; otherwise you may be responsible for all costs incurred before you call. If you are unable to call, have a friend, relative or hospital staff person call for you. The plan's telephone number also is printed on the back of your ID card.

In those cases when you can choose an emergency location, go to the Virginia Mason Medical Center in Seattle or Eastside Hospital in Redmond. This will allow us to coordinate your care efficiently and perhaps reduce your expenses.

If you have an emergency as determined by the plan, you receive benefits for network or non-network care.

If You Need Urgent Care

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention. To receive benefits for urgent care, a network provider must coordinate or provide your care.

- For urgent care during office hours, call your primary care physician's office for assistance.
- After office hours, call Group Health's Consulting Nurse Service at 1-800-910-8884. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your primary care physician for the next day or advise you to go the nearest emergency room.

If You Need Care While Traveling

If you need care while traveling, contact your primary care physician for guidance.

If you are traveling in Eastern Washington and you need care, you may use the Group Health Northwest network and receive the same routine, urgent and emergency benefits you receive in

Western Washington. In Southwest Washington and Northern Oregon, you may use the Kaiser Permanente Northwest network.

If you're traveling to areas other than those specified above, the plan covers emergency care. All other care (including urgent care) is not covered unless a network provider coordinates your care.

If Your Family Member Lives Away From Home

Family members who temporarily or permanently live away from home may be able to access routine, urgent or emergency care at network benefit levels through 2 HMOs associated with Virginia Mason-Group Health Alliance. In Eastern Washington, your family member can use the Group Health Northwest network to receive the same benefits available through the plan in Western Washington. In Southwest Washington and Northern Oregon, your family member can use the Kaiser Permanente Northwest network.

If your family member lives outside of these areas – either temporarily or permanently – this plan covers emergency care only.

Filing a Claim

You don't need to file a claim when you receive care within the network. You may have to submit a claim form for emergency care received by non-network providers.

Send claims to:

Alliant Claims Processing
PO Box 1207
Seattle WA 98111-1207

Claim forms are available from Benefits and Well-Being.

Appealing a Claim

When you become eligible for benefit payments, you must follow certain steps for filing a claim. If your claim is denied in whole or in part, you will be notified in writing of the reason for the denial within 90 days from the date you filed your claim. The notice will include information required if you want to appeal.

You may appeal a denied claim within 60 days of the date you receive the denial notice. This procedure is the only means available to change a benefit decision. To appeal, write to the plan and state the reasons you believe your claim should have been paid.

Include any additional documentation to support your claim. You also may submit questions or comments you think are appropriate, and you may review relevant documents.

Normally, you will receive a written decision on your appeal within 60 days of the date the plan receives your request. If special circumstances require a delay, you will be notified of the extension during the 60 days following receipt of your request.

Appealing a Claim (cont'd)

Send your appeal to:

Appeals Coordinator
Virginia Mason-Group Health Alliance, Inc.
PO Box 34588
Seattle WA 98124-1588

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine the records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Qualified Medical Child Support Order (QMCSO)

The plan provides medical coverage to certain children of yours if directed by certain court or administrative orders. Refer to your "Important Facts" booklet for information.

Coordination of Benefits

This section applies to you if you or an eligible family member is covered by both this plan and a plan not sponsored by the county (and you expect reimbursement from both plans). If you and your eligible family member are covered under a county-sponsored plan both as an employee and as a family member, different rules may apply. Contact Benefits and Well-Being for details.

If you or your family members have additional health care coverage, benefits from the other plan(s) may be considered before benefits are paid under this plan. Additional coverage includes another employer's group benefit plan or other group arrangement – whether insured or self-funded.

The plan that must pay benefits first is considered primary and will pay without regard to benefits payable under other plans. When another plan is primary, this plan will coordinate benefits so you receive maximum coverage. In no case will you receive more than 100% of the covered expense.

If you or your family members are covered under another plan, be sure to keep a copy of your itemized bill and send the bill and Explanation of Benefits to this plan.

If the other plan does not have a coordination of benefits provision, that plan will pay first. If it does, the following rules determine payment:

- The plan covering an individual as an employee will pay first.
- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, the other plan's provisions will apply.)
- If the parents are divorced or legally separated, these rules apply:
  - If the parent with custody (or primary residential placement) has not remarried, the plan of that parent pays before the plan of the parent without custody
  - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody
  - If the court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility will pay first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed will pay first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer these coordination procedures. For example, if the plans paid too much under the coordination of benefits provision, the plans have the right to recover the overpayment from you or your provider.

Coordination of Benefits with Medicare

If you continue to work for the county after age 65 you may:

- Continue your medical coverage under this plan and integrate the county plan with Medicare (the county plan would be primary or pay benefits first).
- Discontinue this medical coverage and enroll in Medicare. If you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months. See "Continuation of Coverage (COBRA)" in the "Important Facts" booklet for details.

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to coverage as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact Benefits and Well-Being.

When Coverage Ends

Refer to your "Important Facts" booklet for information on when coverage ends.

Certificate of Coverage

When your coverage under this plan ends, you will automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under one of these plans. You will need to do this only if the other health plan has a preexisting condition limit.

Continuation of Coverage (COBRA)

Continued coverage is generally available to you and your covered family members under COBRA if coverage ends because of a qualifying event (described below). Refer to your "Important Facts" booklet for information.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the plan benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay, if any, for these benefits.

You will not be able to convert to the individual policy if you are eligible for any other medical coverage under any other group plan.

To apply for a conversion plan, you must complete and return an application form to Alliant within 31 days after this medical coverage terminates. Evidence of insurability will not be required.

Contact Alliant for conversion forms and more information. You will not receive this information unless you request it.

Extension of Coverage

If this plan is canceled, Alliant will continue to cover any participants who are hospital inpatients on the date the plan is canceled. Coverage will end on the date of discharge or when you reach the plan maximums – whichever comes first.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. Refer to your "Important Facts" booklet for information.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, Alliant may have the right to recover the money Alliant paid for benefits. Refer to your "Important Facts" booklet for information.

Recovery of Overpayments

Alliant has the right to recover amounts Alliant paid that exceed the amount for which it is liable. Refer to your "Important Facts" booklet for information.

Payment of Medical Benefits

The medical benefits offered by this plan are funded by Alliant (this is not a "self-funded" plan). This means Alliant is financially responsible for claim payments and other costs of the program.

Termination and Amendment of the Plan

Refer to your "Important Facts" booklet for information on termination and amendment of the plan.

Definitions

To help you better understand your medical benefits, here's a list of important definitions.

Alliant Plan. The Alliant Plan is a medical plan offered by Virginia Mason-Group Health Alliance, Inc. (a subsidiary health care organization owned by Group Health Cooperative of Puget Sound).

Annual Deductible. The amount plan participants pay each plan year before a plan pays benefits. There is no annual deductible for this plan.

Annual Out-of-Pocket Maximum. The most a plan participant pays toward copays and coinsurance each plan year.

Brand-Name Drugs. Trademark drugs patented for a limited period by a single pharmaceutical company.

Chemical Dependency. A psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

Definitions (cont'd)

Chiropractic Care. Manipulation of the spine or extremities to correct a subluxation (incomplete or partial dislocation) demonstrated by an x-ray. The subluxation identified on the x-ray must be consistent with neuromusculoskeletal symptoms related by the patient, and treatment must be within the limits of a specific documented treatment plan. Services must be provided by a state-licensed chiropractor or osteopath. Chiropractors are restricted by law to manipulation of the spine. Osteopaths are licensed to perform manipulative therapy to all parts of the body.

Coinsurance. The amount you and your plan share toward covered expenses. For example, the plan pays 80% coinsurance for ambulance services, which means your coinsurance is 20%.

Copay. The fixed amount you pay at the time you receive the covered service. Not all covered services require copays; see "Medical Plan Summary" starting on page 2 for details.

Custodial Care. Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, dress, eat or prepare special diets or take medication that is normally self-administered.

Dental Care. Care of, or related to, the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies, drugs and devices.

Durable Medical Equipment. Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician.

Emergency. A medical condition that threatens loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

Experimental or Investigational. A condition that exists if any of the following statements apply to it as of the time the service is or will be provided to the plan participant. The service or supply:

- Cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted
- Is the subject of a current new drug or new device application on file with the FDA
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate the safety, toxicity or efficacy of the service
- Is provided under written protocol or other document that lists an evaluation of the service's safety, toxicity or efficacy among its objectives
- Is under continued scientific testing and research concerning the safety, toxicity or efficacy of services
- Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the service's safety, toxicity or efficacy
- Is provided under informed consent documents that describe the service as experimental or investigational, or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:

- Use of the service should be substantially confined to research settings, or
- further research is necessary to determine the safety, toxicity or efficacy of the service.

In determining whether a service is experimental or investigational, the following sources of information will be relied upon exclusively:

- The plan participant's medical records
- The written protocol(s) or other document(s) under which the service has been or will be provided
- Any consent documents(s) the plan participant or plan participant's representative has executed or will be asked to execute to receive the service
- The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body
- The published authoritative medical or scientific literature regarding the service, as applied to the plan participant's illness or injury
- Regulations, records, applications and any other documents or actions issued by, filed with or taken by the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

If 2 or more services are part of the same plan of treatment or diagnosis, all services are excluded if one is experimental or investigational. Alliant consults the appropriate medical staff and then uses the previously specified criteria to decide if a particular service is experimental or investigational.

Formulary. The plan's authorized list of generic and brand-name prescription drugs approved for use by the FDA.

Generic Drugs. Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug.

Hospice. A private or public agency or organization with a hospice agency license that administers or provides hospice care.

Hospital. An institution licensed by the state and primarily engaged in providing inpatient diagnostic and therapeutic facilities for surgical and/or medical diagnosis as well as treatment and care of injured or ill persons by or under the supervision of physicians. The institution also provides 24-hour nursing service by or under the supervision of registered nurses. This definition includes any other licensed institution where the plan has an agreement to render hospital services.

The following are not hospitals: skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or the treatment of pulmonary tuberculosis.

Legend Prescription Drugs. Prescription drugs that have an 11-digit code assigned to them by the labeler or distributor of the product under FDA regulations.

Lifetime Maximum. The maximum benefit amount a plan participant may receive from Alliant in his or her lifetime.

Definitions (cont'd)

Medically Necessary. Appropriate and necessary services (as determined by the plan's Medical Director or his or her designee according to generally accepted principles of good medical practice) rendered to a participant for the diagnosis, care or treatment of an illness or injury. Services and supplies must meet the following requirements:

- Are not solely for the convenience of the patient, his or her family or the provider of the services or supplies
- Are the most appropriate level of service or supply that can be safely provided to the patient
- Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided for preventive services
- Are not primarily for research and data accumulation
- Are appropriate and consistent with the diagnosis and, in accordance with accepted medical standards in the state of Washington, could not have been omitted without adversely affecting the patient's condition or the quality of health services rendered
- As to inpatient care, could not have been provided in a physician's office, the outpatient department of a hospital or a non-residential facility without affecting the patient's condition or quality of health services rendered
- Are not experimental or investigational
- The least costly of available, adequate alternatives (when you are an inpatient, it further means the item cannot be provided safely on an outpatient basis without adverse effect).

Alliant reserves the right to determine whether a service, treatment or supply is medically necessary. The fact a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

Network Provider. A person, group, organization or facility under contract with Alliant to furnish covered services to plan participants.

Non-network Provider. A person, group, organization or facility not under contract with Alliant to furnish covered services to plan participants.

Open Enrollment. The annual period in which eligible King County employees may join a plan or change plans and add or drop family members' coverage.

Physician. A physician licensed by the state in which he or she practices as:

- Doctor of medicine or surgery
- Doctor of osteopathy
- Physician of podiatry.

The plan also covers other providers such as those licensed as a physician's or osteopath's assistant, certified as a nursing assistant, or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by one of the above physicians.

Preauthorization. The plan's approval for medical services or supplies, which is given *before* the patient receives them. Your primary care physician will obtain preauthorization for your care as necessary.

Prescription Drug. Any medical substance that – under the Federal Food, Drug and Cosmetic Act (as amended) – must be labeled with Caution: federal law prohibits dispensing without a prescription.

Primary Care Physician (PCP). A physician under contract with Alliant who provides or coordinates care for plan participants who choose him or her.

Prosthesis. An artificial substitute to replace a missing natural body part.

Provider. A person, group, organization or facility that provides medical services, equipment, supplies or drugs. This includes but is not limited to: acupuncturists, massage therapists and naturopaths. The provider must be practicing within the scope of his or her license.

Referral. An approved, prior authorization by your primary care physician.

Respite Care. Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.

Service Area . The geographic area in Washington state where Alliant is authorized by the Insurance Commissioner to arrange for covered services through agreements with plan providers.

Skilled Nursing Facility. A specially qualified facility that specializes in skilled care. It has staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Care provided in a SNF is care that can only be performed by, or under the supervision of licensed nursing personnel. In addition to skilled care, a SNF usually provides some custodial care.

Temporomandibular Joint (TMJ) Disorders. The temporomandibular joint connects the mandible, or jawbone, to the temporal bone of the skull. TMJ disorders include those with any of the following characteristics:

- Pain in the musculature associated with the TMJ
- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

Urgent Care. Care for a condition that is not life threatening but needs immediate medical attention.

Women's Health Care Services. Include the following health care services:

- Maternity care
- Reproductive health services
- Gynecological care
- General exams and preventive care.

Participant Bill of Rights

Your medical coverage is through Alliant, a health care service contractor. Please take the time to read this booklet so you can get to know the benefits the plan offers.

As an Alliant participant, you have certain rights – refer to your "Important Facts" booklet for more information.

If you have questions about your benefits, call or write Alliant at:

Virginia Mason-Group Health Alliance
1100 Olive Way, Suite 1230
Seattle, WA 98101-1828
206-901-6210 or 1-800-442-4038

Notes

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